The importance of being different

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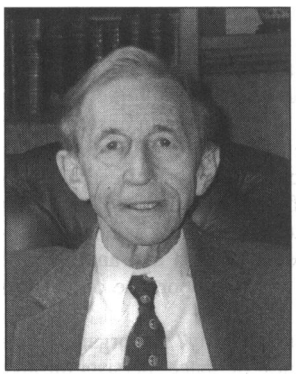

IT is an honour to give the William Pickles Lecture, and it is especially pleasing to give it in this part of Scotland, so near the birthplace of James Mackenzie. Mackenzie and Pickles were two of the most distinguished scientists general practice has produced. Mackenzie did his original research in Burnley on the western edge of the Pennines; Pickles did his in Aysgarth, on the eastern edge, only 35 miles away. Pickles must have known Burnley well, for he married a Burnley woman. There is no indication that the two men ever met. Even so, Pickles was profoundly influenced by Mackenzie's work. It was his reading in 1926 of Mackenzie's *Principles of Diagnosis and Treatment in Heart Conditions* that inspired Pickles to begin his research into the epidemiology of infectious diseases.

Both Mackenzie and Pickles used key features of general practice as foundations of their research method. Mackenzie's observations on the natural history of heart disease depended on his caring for the same patients over many years. Pickles' observations on the spread of infections used his knowledge of person-to-person contacts in his rural practice. Then, as now, our discipline's greatest contributions to medicine sprang from the things that made it different.

In an article based on interviews with all 12 academic general practitioners (GPs) and a sample of full-time GPs in Scotland in 1975, Reid[1] described the academic GPs' sense of alienation from the academic mainstream, and from their colleagues in full-time practice. They felt 'marginal' in the medical school. Academic general practice has made considerable progress since then, yet we still, I believe, do not fit comfortably into the academic milieu. To gain acceptance, it is said, general practice must become less pragmatic, more theoretical and more productive in quantitative research. My own view is that general practice is marginal because it differs in fundamental ways from the academic mainstream and that our value to medicine lies in the differences. Eventually, I think, the academic mainstream will become more like us than *vice versa*. I will describe four ways in which general practice is different, most of which are shared with other primary care disciplines.

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1. It is the only discipline to define itself in terms of relationships, especially the doctor–patient relationship

Other fields define themselves in terms of content: diseases, organ systems or technologies. Clinicians in other fields form relationships with patients, but in general practice, the relationship is usually *prior* to content. We know people before we know what their illnesses will be. It is, of course, possible to define a content of general practice, based on the common conditions presenting to GPs at a particular time and place. But, strictly speaking, the content for a particular doctor is whatever conditions her patients happen to have. Other relationships also define our work. By caring for members of a family, the family doctor may become part of the complex of family relationships, and many of us share with our patients the same community and habitat.

Defining our field in these terms has consequences, both positive and negative. Not to be tied to a particular technology or set of diseases is liberating. It gives general practice a quality of unexpectedness and a flexibility in adapting to change. On the other hand, it is poorly understood in a society that seems to place less and less value on relationships. One major consequence is that we cannot be comfortable with the mechanical metaphor which dominates medicine, or with the mind/body dualism derived from it. Another is that the value we place on relationships influences our valuation of knowledge. Those who value relationships tend to know the world by experience rather than by what Charles Taylor[2] calls 'instrumental' and 'disengaged' reason. Experience engages our feelings as well as our intellect. The emotions play a very significant part in general practice, and as I will maintain, are seriously neglected in medicine as a whole.

2. General practitioners tend to think in terms of individual patients rather than generalized abstractions

When the conversation is about a disease, we are likely to say: 'That reminds me of Mrs X.' We have difficulty thinking about diseases as separate from the people who 'have' them. Reid[1] observed of the full-time GPs she interviewed that some 'could not talk about general practice except in terms of their specific patients'. This trait, I believe, arises from the intimacy of the doctor–patient relationship in general practice. The closer we are to a person, the more we are aware of their individual particulars, and the more difficult it is to think of them as members of a class. 'We instinctively recoil,' wrote William James, 'from seeing an object to which our emotions and affections are committed, handled by the intellect as any other object is handled. The first thing the intellect does with an object is to class it along with something else. But any object that is infinitely important to us and awakens our devotion feels to us as if it must be *sui generis* and unique.'[3]

In classifying, we distance ourselves from experience. In Umberto Eco's novel *The Name of the Rose*,[4] Brother William explains to Adso how he identified the abbot's horse as they climbed the hill to the monastery: 'If you see something from a distance, and you do not understand what it is, you will be content with defining it as an animal, even if you do not know whether it is a horse or an ass. And when it is still closer you will be able to say it is a horse, even if you do not yet know its name. Only when you are at the proper distance will you see that it is Brucellus, the abbot's horse, and that will be full knowledge, the learning of the singular.'*

The closer we are, the fuller our knowledge of particulars. The greater the distance, the greater the degree of abstraction. Medicine has gained great predictive power by distancing itself enough from individual patients to see the abstraction (the disease) rather than the individual. This is now what we refer to as the diagnosis, although in former times physicians spoke of diagnosing a patient, not a disease. If we look closely, every patient is different in some way. It is in the care of patients that knowledge of particulars becomes crucial. Care is about attention to detail. 'Caring is not about categories,' wrote Arthur Frank,[5] reflecting on his own illness. 'A large acquaintance with particulars,' said William James,[3] 'often makes us wiser than the possession of abstract formulas, however deep.'

Of course, we need the abstractions too, especially for making causal inferences and applying powerful technologies. The ideal is an integration of the two kinds of knowledge: an ability to see the universal in the particular. There are penalties for dwelling too much in one or the other. For physicians who dwell too much in the particulars, there is a risk of missing the forest for the trees. For those who dwell too much in abstractions, the risk is detachment from the patient's experience and a lack of feeling for his or her suffering. Abstraction produces accounts of experience that, stripped of their affective colouring, are far removed from the realities of life.

These two kinds of knowledge are illuminated by Alfred Korzybski's[6] vivid metaphor of the map and the territory. We can get to know a territory by studying the map, which is made by abstracting certain features and ignoring others. The map helps us to find our way, but knowing the territory from the map is not the same as knowing it by dwelling in it. A native knows his territory by feeling part of it. His knowledge is visceral, much of it tacit and difficult to articulate, as with the peasant farmer who knows that a new scheme will not work on his land, but cannot give his reasons to the expert. We cannot experience the beauty or the terror of a landscape by reading the map. Of course, one can get passionate about maps. There is a thrill in making a good diagnosis (finding our place on the map), and there can be beauty in a radiograph. But this is not the same as a feeling for the patient's experience of illness — and patients are very quick to sense the difference. If we are to be healers as well as technicians, we have at some point to set aside our maps and walk hand-in-hand with our patients through the territory.

In the modern university, abstraction and disengaged reason reign supreme. Knowledge has been separated from experience, thinking from feeling. The educational challenge we face is correcting, in Margaret Donaldson's[7] words, 'the imbalance between intellectual and emotional development'. In medicine, the standard diagnostic method is an outstanding example of the imbalance. The physician is required to categorize the illness, but not to attend to the patient's feelings or understand his experience. Stephen Toulmin[8] contrasts the modern paradigm of knowledge with the one which dominated the learned world of the Renaissance, when scholars were 'as concerned with circumstantial questions of practice in medicine, law or morals, as with any timeless, universal matters of philosophical theory.' With the coming of the Enlightenment, this was replaced by a paradigm which removed knowledge from its context: *'abstract axioms were in, concrete diversity was out, general principles were in, particular cases were out.'* I suspect that some of our discomfort in the medical school is due to our different valuation of knowledge.

*Excerpt from *The Name of the Rose* by Umberto Eco, © 1980 by Gruppo Editoriale Fabbri-Bonpiani, Sonzogno, Etas S.p.A., English translation ©1983 by Harcourt Brace & Company and Martin Secker & Warburg Ltd., reprinted by permission of Harcourt Brace & Company and Martin Secker & Warburg Ltd.

3. General practice is based on an organismic rather than a mechanistic metaphor of biology

The metaphors we use in medicine are often very revealing about the way we think. The metaphor of the human body as a machine speaks volumes about the modern idea of healing. Even though the body has some machine-like features, everything we do for the health of the body depends on the healing powers of nature. Living organisms have properties possessed by no machine: growth, regeneration, healing, learning, self-organization and self-transcendence. At its most successful, medicine works in supporting these natural processes. Surgeons drain abscesses, set fractures, repair wounds, relieve obstructions. Immunization strengthens the organism's defences. The most effective drugs are those which support natural defences and maintain balance in the *milieu interieur*. The traditional regimens of balanced nutrition, rest, sound sleep, exercise, relief of pain and anxiety, and personal support are all measures which support the organism's healing powers.

What does it mean to think organismically? An organism is a particular, that is 'it occupies a region of space, persists through time, has boundaries and has an environment.'[9] The point about particulars is that their behaviour cannot be explained or predicted solely by applying the general laws of science. Whether or not the law will apply to a particular will depend on its history and its context or environment. There is an inherent uncertainty about all particular applications of general scientific principles. The more complex the particular, the greater the uncertainty, and a sick patient is a very complex organism. To think organismically is to 'think complexity' and to accept uncertainty. Generalizations must be framed in terms such as: 'given this context, the following will for the most part apply.' Of all the clinical disciplines, general practice operates at the highest level of complexity.

Organismic thinking is multilevel and non-linear. Organisms maintain themselves in a state of dynamic equilibrium by a reciprocal or circular flow of information at all levels, and between organism and environment. Through these multilevel channels, change in any part can reverberate through the whole organism and to its surroundings. The necessity of constant information flow can be seen in the destabilizing effects on humans of sensory deprivation. Information is carried in the form of symbols conveying messages that are decoded at the appropriate level of the organism. At lower levels, information is carried by hormones and neurotransmitters. At the level of the whole organism, it is carried by stimuli reaching the special senses, among which are the words and other symbols by which meaning is expressed in human relationships. This provides the background for our accumulating knowledge of the effect of relationships on health and disease.

The transition from mechanistic to organismic thinking requires a radical change in our notion of disease causation. Medicine has been dominated by a doctrine of specific aetiology: a cause for each disease. We have learned to think of a causal agent as a force acting in linear fashion on a passive object, as when a moving billiard ball hits a stationary one. In self-organizing systems such as organisms, causation is non-linear. The multiple feedback loops between organism and environment, and between all levels of the organism, require us to think in causal networks, not straight lines. Moreover, the organism is not a passive object. The 'specific cause' of an illness may only be the trigger which releases a process that is already a potential of the organism. The causes which maintain an illness and inhibit healing may be different from the causes which initiated it, and these may include the organism's own maladaptive behaviour. Therapeutic measures may act not on a causal agent, but on the

body's defences, as appears to be the case with the therapeutic benefits of human relationships. In a complex system, cause and effect are not usually close to each other in time and space, and since organic processes are maintained or changed by multiple influences, it is difficult to predict the consequences of an intervention.[10] It is true that we can still isolate one link in the causal network as our point of intervention, as when we prescribe an antibiotic, but even in these instances we should be aware of the whole context in which we are operating, and of the reciprocal effects of our intervention. The complexity of the illnesses we encounter in general practice make it natural for us to think in this way. Does isolation from social supports cause depression, or does depression cause the isolation? Did this life event cause the depression or was it only the trigger, releasing a depression in a susceptible individual? In human science, we can establish relationships between events, but it is often difficult to establish cause. Does this imply therapeutic impotence? No, but it does require a change from simplistic causal thinking to thinking about how change can be facilitated in complex systems.

With the transition from mechanistic to organismic thinking, either/or questions become meaningless, especially those which take the form 'Is disease X psychogenic or organic?' A recent editorial in the *New England Journal of Medicine* said: 'Migraine is a neurobiologic, not a psychogenic disorder.'[11] Why can it not be both?

In their capacity for self-organization, learning and self-transcendence, organisms behave in a way that is 'mindful'. This is not simply a mind 'in the brain', but one which is immanent in the whole body. Every level of the organism — from the molecular upwards — has a capacity for autonomous activity and for integrating its activity with the whole. Each level can transmit and receive coded messages that convey meaning. The immune system, for long thought to be isolated, is connected reciprocally with the neuroendocrine systems through neural networks and circulating neurotransmitters. The immune system can learn from experience and can distinguish 'self' from 'not self'. A large body of evidence indicates that emotions can influence immune function, thus providing a physiological link between life experience and the course and outcome of illness.[12] As John Cassell[13] predicted, relationships act at this intermediate level of host resistance, not as causal agents for specific diseases. Social isolation, for example, increases mortality from virtually all causes of death. The notion of a separate group of psychosomatic diseases is therefore obsolete. In any disease, social factors can be part of the causal web and human relationships can be part of the healing process.

The immanent mind knows the world through bodily feelings. The separation of thinking from feeling, and the relegation of emotion to a limited role, is being rendered untenable by cognitive science. Psychologists from Freud to Piaget have shown that thinking and feeling do not occur in isolation: emotion is necessary for cognition, especially for giving meaning to our experience. Neuroscience now tells us that the connection is embodied in the structure and function of the brain.[14] Experiences that are significant to us are laid down as memory in our neural circuits, with the affective colouring which imbues them with meanings for us. The events of our lives are woven into a personal narrative which not only gives us our sense of self, but enables us to interpret and give personal meaning to each new experience.[15] The 'body as machine' is replaced by a new metaphor — the embodied mind[16] — and our new language speaks of the mind–body, not the mind *and* the body. Our understanding comes from bodily experience of the world interpreted always in terms of our personal story. This approach takes very seriously the knowledge derived from experience. When applied to medicine, it makes patients' experiences of illness an important aspect of medical knowledge. This is the domain of qualitative research — a natural field of inquiry for general practice.

I believe we are living through the final breakdown of the dualistic world view — a situation with profound implications for us, as we turn to the fourth difference.

4. General practice is the only major field which transcends the dualistic division between mind and body

This division runs through medicine like a geological fault. Most clinical disciplines lie on one side or the other: internal medicine, surgery and paediatrics on one side; psychiatry, child psychiatry and psychogeriatrics on the other. Separate taxonomies of disease lie on either side: textbooks of medicine and surgery on one, the *Diagnostic and Statistical Manual of Mental Disorders* on the other. We divide therapies into the physical and the psychological. In clinical practice, internists and surgeons do not normally explore the emotions, psychiatrists do not examine the body. Since general practice defines itself in terms of relationships, it cannot divide in this way.

Without this artificial barrier, the relationship between patient and doctor can develop through many encounters for all kinds of illness. In examining and attending to the body, we are also attending to the mind. Mental states are expressed in posture, movement and muscle tone, and examining the body can trigger the expression of feeling. Body therapies can heal the mind; mental therapies can heal the body. Psychotherapy need not be separate from therapy for the body: indeed, it is doubtful whether in general practice we should call it 'psychotherapy'. For most of us, I suspect, it is a question of listening, supporting, reassuring, encouraging the expression of feelings and the reinterpretation of perceptions we call cognitive therapy. This is something we do for all patients, not only for those with 'psychiatric' illness. The more we learn about the placebo effect, the more it appears to be the healing power of the doctor–patient relationship through symbolic acts and rituals.[17] Since the effect is strengthened by each new experience of the relationship, it has a special importance for us in general practice. In the course of time, the relationship with the doctor can become part of the patient's own narrative. I began by saying that general practice has no technology to call its own. I will now modify this and say that our therapeutic tool is ourselves in the healing relationship — the drug 'doctor' as Balint called it.[18]

One of the legacies of dualism is the clinical method we have inherited from the nineteenth century, a method which leaves it to psychiatrists to attend to the emotions. It is not surprising, therefore, that moves to reform our clinical method have come from general practice. The essence of the patient-centred method[19] is that the doctor attends to feelings, emotions and moods, as well as categorizing the patient's illness. What does it mean to attend to a patient's feelings, emotions and moods? Understanding the emotions is person to person, and we cannot attend to another person's emotions without attending to our own. The key skill is attentive listening. To listen to a person with total, undivided attention is one of the greatest gifts we can bestow.[20] It is listening not only with our ears, but with all our faculties, especially with an open heart. We cannot do this if our eyes are on our 'map' or if we are thinking what to say next, or if we are consumed by our own negative emotions. If we can achieve this state of openness, we find that our responses to the patient spring naturally from some inner source. Needleman[21] describes this attentive state as 'non-egoistic, impersonal love', a love we call charity (to the Greeks *agape*). It is not an emotion in

the usual sense and does not depend on affection. The Good Samaritan did what was needful for the man he rescued, then went on his way. As physicians we can do likewise, whatever our discipline. But for general practitioners, there is an additional dimension — the long-term relationship with patients, in the course of which affections grow. Of the four loves — affection, friendship, eros and charity — C. S. Lewis[22] called affection the humblest and most widely diffused. When combined with charity, the warmth of affection must surely be a healing force, but it comes with a price, for the relationship between doctor and patient is subject to the same stresses and weaknesses as other human relationships. So we see both love and hate, trust and mistrust, betrayal and forgiveness, irretrievable breakdown and survival of the relationship in spite of difficulties. Unacknowledged negative emotions, such as fear, helplessness, anxiety, anger and guilt, may be acted out by the doctor in avoidance, indifference, rejection and even cruelty. The doctor's own need for affection may be stronger than his ability to give it. It is the egoistic emotions, so destructive of human relationships, that prevent us from responding to suffering with our authentic feelings. The priest and the Levite 'passed by on the other side', no doubt giving themselves very good reasons.

We can only attend to a patient's feelings and emotions if we know our own, but self-knowledge is neglected in medical education, perhaps because the path to this knowledge is so long and hard. Egoistic emotions often come disguised as virtues and we all have a great capacity for self-deception. But there are pathways to this knowledge and medical education could find a place for them. Could medicine become a self-reflective discipline? The idea may seem preposterous. Yet I think it must, if we are to be healers as well as competent technologists. By living in a world of abstractions and neglecting our own emotional development, we have erected an invisible barrier between ourselves and our patients. We protect ourselves by growing a hard shell which makes openness difficult, and our patients interpret this as cold indifference or rejection. A contemporary novelist has referred to our profession's 'stunted emotions'.[23] Even psychiatry is not a model of self-reflectiveness. As Bettelheim[24] and Needleman[21] have noted, psychiatry has directed its attention more to *other people's* emotions. Rather than turn our attention inwards, we are driven by our culture to put our faith in new abstractions such as systems theory, not seeing that, however useful they may be as 'maps', they can come between us and our patients.

The four differences I have described are all of a piece. Giving primacy to long-term relationships directs our attention to the particulars of illness; and the complexity of illness in the context of relationships makes it difficult for us to think in mechanistic and dualistic terms. But we have hardly begun to see the advantages of our position. Transcending the 'fault line' should make general practice the ideal therapeutic setting for the many disorders which, like chronic pain, do not fit neatly on one side or the other. The more we learn about the effect of supportive relationships on cancer and other chronic diseases, the more redundant the fault line becomes.[25,26] To realize our potential, however, we have other work to do. Thinking in the way I have described may be natural for us, but it is still difficult, for we are all, to some extent, prisoners of an unreformed clinical method and the language of linear causation and mind/body dualism. The fault line runs through the affect-denying clinical method which dominates the modern medical school. Not until this is reformed will emotions and relationships have the place in medicine they deserve. Finally, to become self-reflective, medicine will have to go through a huge cultural change. In these changes, general practice is already some distance along the way. The importance of being different is that we can lead the way.

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